LOS ANGELES COUNTY COMMISSION ON HIV
3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
http://hiv.lacounty.gov

EXECUTIVE COMMITTEE

MEETING AGENDA

Monday, May 22, 2017 | 1:00pm – 3:00pm

Commission on HIV (COH) Offices
3530 Wilshire Boulevard, Suite 1140
Los Angeles, CA 90010

All Committee Meetings Will Begin at Their Appointed Times; Participants Should Make Every Effort to be Prompt and Ready.

AGENDA ITEMS	MOTION(S)	Reporting/ Presenting Parties	TIMES SCHEDULED
1. **Call to Order**		**B Land/R Rosales,** Co-Chairs	1:00pm — 1:02pm
2. **Approval of Agenda**	**MOTION #1**	**Committee**	1:02pm — 1:05pm
3. **Approval of Meeting Minutes**	**MOTION #2**	**Committee**	1:05pm — 1:07pm
4. **Public Comment** ***(Non-Agendized or Follow-Up)***		**Public**	1:07pm — 1:10pm
5. **Committee Comment** ***(Non-Agendized or Follow-Up)***		**Commission Members/Staff**	1:10pm — 1:13pm
6. **Executive Director's Report** **A.** Assessment of the Administrative Mechanism (AAM) Update **B.** 2017 Colloquia Series **C.** COH Annual Meeting		**C Barrit, MPIA,** Executive Director	1:13pm — 1:30pm
7. **Co-Chairs' Report** **A.** Executive Committee Meeting Schedule Review		**B Land/R Rosales,** Co-Chairs	1:30pm -- 1:35pm
8. **Division of HIV/STD Programs (DHSP) Report**		**M Peréz, MPH,** Director, DHSP	1:35pm — 1:55pm
9. **Integration Advisory Board (IAB) Report**		**A Ballesteros, MBA/B Gordon** IAB Co-Chairs	1:55pm — 2:00pm

AGENDA ITEMS	MOTION(S)	Reporting/ Presenting Parties	TIMES SCHEDULED
10. Standing Committee Reports		**Committee**	2:05pm — 2:45pm
A Planning, Priorities and Allocations (PP&A) Committee		A Ballesteros, MBA/J Brown, Co-Chairs	
(1) PS12-1201 Comprehensive HIV Prevention Programs End of Year Progress Report			
(2) DHSP Solicitation Schedule/Summary			
B Standards and Best Practices (SBP) Committee		J Cadden, MD/G Granados, MSW, Co-Chairs	
(1) Prevention Standards			
(2) Housing Standards			
C Operations Committee		T Bivens-Davis/K Stalter, Co-Chairs	
(1) Policies and Procedures			
(2) Membership Management			
(a) 2017 Member Cohort			
(3) Training/Orientation			
D Public Policy Committee		A Fox, MPM/W Watts, Esq., Co-Chairs	
11. Caucus, Task Force and Work Group Reports		**Committee**	2:45pm — 2:55pm
A. Caucuses			
(1) Consumer Caucus		J Green/J Munoz/Y Sumpter, Co-Chairs	
(2) Women's Caucus		B Gordon/Y Salinas, Co-Chairs	
B. Task Forces			
(1) Housing Task Force		T Goddard, MA/R Ronquillo, Co-Chairs	
(2) Long Beach Task Force		TBD	
(3) Transgender Task Force		M Roman/D Cortez, Co-Chairs	
C. Work Groups			
(1) Community Engagement Work Group		T Bivens-Davis, Chair	
(2) CHP Goals and Objectives Work Group		G Granados, MSW/K Stalter, Co-Chairs	
12. Next Steps		**Committee**	2:55pm — 2:58pm
A Task/Assignment Recap			
13. Announcements		**Committee and Public**	2:58pm — 3:00pm
14. Adjournment		B Land/R Rosales, *Co-Chairs*	3:00pm

PROPOSED MOTION(s)/ACTION(s):

MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve the Executive Committee meeting minutes, as presented.

EXECUTIVE COMMITTEE MEMBERS:			
Brad Land, *Co-Chair*	Ricky Rosales, *Co-Chair*	Al Ballesteros, MBA	Traci Bivens-Davis
Jason Brown	Joseph Cadden, MD	Raquel Cataldo	Kevin Donnelly
Aaron Fox, MPM	Grissel Granados, MSW	Joseph Green	Mario Pérez, MPH
Kevin Stalter	Will Watts, Esq.		
QUORUM	**8**		

ALL AGENDA ITEMS ARE SUBJECT TO ACTION ▣ PUBLIC COMMENT WILL BE INVITED FOR EACH ITEM

The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie. Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge upon request. To arrange for these services, or for additional information about this committee, please contact Dawn McClendon at (213) 639-6716 or dmcclendon@lachiv.org.

Servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Dawn McClendon al (213) 738-2816 (teléfono), o por fax al (213) 637-4748, por lo menos cinco días antes de la junta.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER

Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of an a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests—from members or other stakeholders—within the limitations and requirements of other possible constraints.

PS12-1201: Comprehensive HIV Prevention Programs for Health Departments

LOS ANGELES COUNTY
END OF YEAR PROGRESS REPORT

Reporting period covers
January 1, 2016 – December 31, 2016

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PROGRESS REPORT (Project Narrative)

Directions: Please answer the following questions for your End of Year Progress Report.

The End of Year Progress Report requires the grantee to report on progress made during the Year 05 reporting period, January 1, 2016 – December 31, 2016. Unless otherwise noted, responses to the questions in this guidance should accurately reflect program activities conducted during the reporting period of January 1, 2016 – December 31, 2016. Your report is due to CDC no later than March 31, 2017. Please email your report to the ps12-1201@cdc.gov mailbox and your assigned PPB Project Officer with a courtesy copy to your assigned Grants Management Specialist (GMS).

HEALTH DEPARTMENT CONTACT INFORMATION					
Award Number:	5U62PS003680-5				
Health Department:	County of Los Angeles, Department of Public Health, Division of HIV and STD Programs (DHSP)				
Mailing Address:	600 S. Commonwealth Ave., 10th Floor				
City:	Los Angeles	**State:**	CA	**Zip Code:**	90005
Phone Number:	(213) 351-8000			**Fax:**	(213) 387-0912

Primary and Secondary Contact Information	Title/Position	Name	Phone	E-mail Address
Primary	Director, DHSP	Mario J. Pérez, MPH	(213) 351-8001	mjperez@ph.lacounty.gov
Secondary	Chief, Office of Planning	Michael Green, PhD	(213) 351-8002	mgreen@ph.lacounty.gov

Contact Information for HIV Prevention and Care Planning Group	Name	Phone	E-mail Address	Length of Term
Health Department Co-Chair	N/A			
Community Co-Chair	Ricky Rosales	(213) 202-2750	Ricky.rosales@lacity.org	3 Years
Community Co-Chair	Brad Land	(213) 738-2816	BGLinc@aol.com	3 Years
HIV Planning Group Executive Director	Cheryl Barrit	(213) 738-2816	cbarrit@lachiv.org	

***If your jurisdiction has more than two co-chairs, please add their information in the table (i.e., rural and urban, prevention and care, etc.).**

The following questions are core questions to be used for programmatic and data reporting, for the reporting period of January 1, 2016 – December 31, 2016.

SECTION I: CATEGORY A: Required Core HIV Prevention Program
All four required core components should be implemented during this reporting period.

- ☒ HIV Testing
- ☒ Comprehensive Prevention with Positives
- ☒ Condom Distribution
- ☒ Policy Initiatives

Please provide responses to the following questions for the required core components for Category A. Responses to questions should include all four required components.

1. Describe any **substantial changes** made to your HIV prevention program for any of the four required core components funded under Category A during the reporting period. Please describe the changes made for the specific the program component.

HIV Testing (Non-Healthcare Settings):

Under Category A, HIV testing is primarily taking place in non-healthcare settings. For testing in healthcare settings, see Section II: Category B: Expanded HIV Testing Program.

For HIV testing in non-healthcare settings, **there have been no substantial changes** to any of the testing program modalities (multiple morbidity, Commercial Sex Venues, other targeted testing sites) during the reporting period (January-December 2016).

Through December 2016, Los Angeles County (LAC) is at 98% (65,636/67,000) of our projected HIV testing goal for non-healthcare settings. This number and percent include data from the City of Long Beach (LB) reported by the Division of HIV and STD Programs (DHSP), but provided by the State of California. Additionally, some programs provide targeted testing through Category A in both non-healthcare and healthcare settings. See Section VII of the report for additional information.

As previously reported, for 2014 through 2016 we reduced our annual targets under Category A to 67,000 HIV testing events (per year), while maintaining our goal for positivity rate.

Mobile HIV/STD Testing Unit

During this reporting period, the DHSP Mobile Testing Unit (MTU) was only operational for a four week period and key staff were on leave. Staff were reassigned to provide testing within partnering agencies. This included testing at youth homeless shelters and developing agreements to test residents in City of Los Angeles low-income housing areas.

Comprehensive Prevention with Positives:

Risk Reduction Activities (RRA)

There have been no substantial changes to any of the prevention with positive programs.

Partner Services

This year proved to be a pivotal planning year for re-structuring and reprioritizing HIV/STD Partner Services within LAC. In response to the steady increase of syphilis (including congenital syphilis), gonorrhea (GC), and chlamydia (CT) cases in LAC over the last several years and in light of the increasingly scarce human and financial resources available to aggressively investigate all cases and interrupt the transmission of new infections, DHSP employed a priority-setting process for local disease investigation efforts in 2016.

The revised Partner Services protocol de-prioritized CT and GC partner services activities and focused on prioritized HIV and syphilis partner services. Public Health Nurses as well as Public Health Investigators (i.e, Disease Investigation Specialists) from the Public Health Department external to DHSP were included in this prioritization process. In addition, the changes included but are not limited to: assigning all pregnant females with HIV to Public Health Nurses, reducing CT and GC follow-up activities for treated cases, assigning priority syphilis cases of females of reproductive age to Public Health Nurses, assigning high priority syphilis cases to Public Health Investigators, PHIs co-located STD clinics (non-DHSP staff), and improving the use of HIV Surveillance for HIV cases.

In 2016, DHSP in coordination with Community Health Services (CHS), PHI Administration, and the Bureau of the Medical Director/Disease Control, reached consensus regarding the new prioritization protocol and developed an implementation and training plan. The protocol changes

are slated to launch in April 2017. The changes were rooted in a data driven process based on the Centers for Disease Control and Prevention's (CDC) ***Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection*** (2008) and was further refined in consultation with the California STD Control Branch, the CDC, the University of Washington Public Health Capacity Building Center (who serves as the CDC's Partner Services Capacity Building Agency) as well as public health leaders from other highly impacted state and municipal jurisdictions.

Partner Services and STD Surveillance Data Efforts

In addition to restructuring DHSP's Partner Services unit to better respond to the workload and changing priorities, DHSP's STD Surveillance unit made significant changes to re-program LAC's STD Surveillance database which is also utilized as the Partner Services case management system.

Training and Technical Assistance

To implement the changes, training, presentations, and technical assistance were provided to DPH staff, in particular Public Health Investigators and Public Health Nurses. DHSP worked closely with the CDC capacity building assistance providers to identify training needs and develop trainings for Public Health Nurses. Specifically, training surrounding HIV disclosure and stigma issues were requested training topics that will be provided in early 2017. In addition, Public Health Investigation staff participated in presentations, meetings, and conferences that highlighted the rationale for prioritizing HIV and syphilis cases for Partner Services activities.

Use of HIV Surveillance for Partner Services and Linkage and Re-engagement to HIV Care

DHSP has begun utilizing HIV Surveillance for linkage and re-engagement activities for individuals who are lost or not linked to HIV care via the HIV Linkage and Re-engagement Program (LRP) activities. LRP launched in late February 2016. Preliminary data show that referrals from providers yield better outcomes than utilizing HIV Surveillance as a referral source. However, the HIV Surveillance system has proven to be critical in determining a client's true HIV care disposition, current addresses, and other useful information. The approval for the

broad use of HIV Surveillance for Partner Services activities was provided by DHSP's HIV Surveillance unit in late 2016. Protocols for these activities will be finalized in 2017.

Perinatal

In February 2016, Ms. Amy Danzig was identified and hired for the Medical Records Abstractor (MRA) position. The continued operation and progress of the Enhanced Perinatal Surveillance (EPS) are dependent on only one staff member, the Medical Records Abstractor. Working under the direct supervision of the EPS project manager and epidemiologist, Ms. Azita Naghdi, the MRA has been responsible for assisting the Los Angeles County Department of Public Health Pediatric HIV/AIDS surveillance staff to report prevalent and incident cases of pediatric HIV exposure and infection. In addition, Ms. Danzig has been assisting in the review of mother and infant medical records and abstraction of pertinent information to complete supplemental EPS abstraction forms at participating hospitals and clinics; maintaining multiple databases for EPS; data entry; conducting follow-up with health care providers and laboratories to obtain missing surveillance information; participating in CDC-sponsored conference calls; helping secure IRB approval at the different LAC EPS sites; attending relevant trainings for HIPAA regulations; and ensuring that surveillance practices are consistent with security and confidentiality policies and procedures. Unfortunately, due to limited manpower in past years, timeliness of identifying and following-up on HIV-exposed infants and subsequent abstraction of electronic medical records at our largest perinatal HIV-specialty center, LAC+USC, remains incomplete. For the reporting period January 1, 2016 to December 31, 2016, we were able to complete only 35% of the medical record abstractions at this facility.

In June 2016, an updated Pediatric HIV Confidential Case Report form (PCRF) and Pediatric HIV Exposure Reporting form (PHER), with changes made to sections pertaining to laboratory data, birth history, treatment and service referrals were approved by the CDC and distributed to jurisdictions for data collection purposes.

During this reporting period, Ms. Naghdi was also notified of Dr. Hindo's (PI of the EPS project at Cedars-Sinai Medical Center) departure. This has caused a delay in the submission of the annual IRB continuing review at this facility until a new PI has been identified. In November of 2016, Dr. Vikram Anand was hired as Dr. Hindo's replacement. A meeting was scheduled

between him and Ms. Naghdi, where his role as the new PI for the EPS project at Cedars-Sinai Medical Center was discussed and his duties agreed upon. Necessary modifications and amendments are being made to the IRB before facility approval can be granted.

Condom Distribution:

No changes to report.

Policy Initiatives:

In 2016, we focused on the implementation of our Los Angeles County PrEP implementation strategy which revolves around three goals: 1) increasing consumer awareness of PrEP, 2) increasing provider awareness and use of PrEP, and 3) creating a safety net access system for PrEP. We were pleased to see the passage of a California state bill that now requires HIV post-test counseling which requires a conversation regarding PrEP; the bill provides us more traction in requiring our funded HIV test counselors to attend a PrEP 101 training and to begin integrating PrEP education and referrals into their testing programs. We have also been tracking a state bill that would decriminalize the transmission of HIV that would have dramatic implications for our work in destigmatizing HIV.

2. Describe the **successes** experienced with implementing your HIV prevention program for each of the four required core components funded under Category A during the reporting period. Please specify the program component associated with the successes.

HIV Testing (Non-healthcare settings):

Although we were not able to maintain the 1.0% FOA requirement (see Challenges section), the testing program continued to operate successfully during the reporting period, with testing programs experiencing high testing volume. Testing events took place during Pride events, national testing days, and as a part of the First Ladies Healthcare Initiative which encouraged HIV testing on church property throughout the county; mobile testing sites were constantly assessed using mapping; HIV testing in Storefront Sites and Social Network Sites continue to increase in volume. The number of tests conducted by the Mobile Unit program remained constant.

Multiple Morbidity

Since 2000, DHSP has partnered with three contracted agencies – California State University Long Beach (CSULB), Valley Community Healthcare (previously Valley Community Clinic), and JWCH Institute – to provide multiple morbidity testing services in all eight Service Planning Areas (SPAs) in LAC. In late 2013, APLA Health and Wellness was added, and DHSP initiated mobile HIV/STD testing services targeting the Second Supervisorial District (central and south LAC). In 2015, CSULB's Center for Behavioral Research terminated their MSM MTU program. However, DHSP has continued to expand STD testing with HIV service providers targeting MSM populations throughout the County.

The multiple morbidity testing services provide screening for acute and chronic hepatitis B and C, syphilis, chlamydia, gonorrhea, and HIV all within one visit. Table A shows the number of tests performed during this reporting period.

Table A. DHSP Multiple Morbidity Screening Program, Screening Data, January 1 – December 30, 2016

Agency Name	CT	GC	Syphilis	HBV	HCV
	Tests	Tests	Tests	Tests	Tests
JWCH Institute MTU	656	656	383	0	356
Valley Community Healthcare	596	596	605	0	576
AIDS Project Los Angeles	1,111	1,119	1,056	0	103
DHSP-operated MTU	63	66	58	x	x
Total	2,426	2,437	2,102	0	1,035

DHSP continued to convene HTS Program Coordinator meetings. Topics covered at the three meetings held during the reporting period (March 18th, June 14th and October 27th) included a presentation on DHSP's Linkage and Re-engagement Program, testing events, PrEP training, viewing/presentation of AltaMed Health Services telenovela "Sin Verguenza", STD update, and provided programmatic and administrative updates and information such as 2015 HIV Data Quality Assurance, Competency Assessments, Counselor Database, and Distribution of Incentives. DHSP staff also presented HIV testing data and reviewed data submission deadlines.

DHSP Mobile HIV/STD Testing Unit

Despite not having a mobile testing unit to conduct testing activities, DHSP's MTU team explored other community partnerships to increase visibility and testing opportunities via established sites and continued to target high-risk populations. DHSP counselors began providing comprehensive STD screening and testing including HIV, syphilis, gonorrhea and chlamydia at Transitional Age Youth (TAY) centers and shelters. As there were no existing HIV/STD services for these high-risk homeless youth, DHSP staff were filling a critical need. DHSP is currently providing HIV/STD testing services in six locations serving the homeless, veteran and TAY populations in South LA, populations that experience a disproportionately high burden of disease. Additionally, DHSP works closely with our partners to respond to requests to be a visible presence in the community. This included holding a World AIDS Day Testing Event at a Community Education Center. DHSP is also working with the City of Los Angeles to establish a memorandum of understanding (MOU) to provide testing services in low-income housing projects.

Finally, a comprehensive set of staff development trainings was implemented with all MTU staff, thereby increasing staff competency around the needs of high-risk youth and transgender populations. Trainings included various topics, such as bio-medical prevention options (PrEP and PEP) and identification and awareness of commercially sexually exploited children (CSEC).

Comprehensive Prevention with Positives:

RRA

These programs continued to see participants in the various interventions included in the prevention with positives programs. Individual-level interventions were the most common form of contact with the target population. However, groups continue to be well attended and were a source of support for participants in relation to medication adherence, enrollment and/or retention in care and disclosure of HIV status to partners. Staff of these programs have also participated in trainings on PrEP and PEP and have begun to include these discussions in the group curricula and during individual counseling sessions. During the second half of the reporting period, programs dedicated significant discussion time related to the continuation of health care coverage and the options clients have in LAC.

Partner Services

Support from DPH leadership to refine and enhance Partner Services priorities was crucial. In addition, DHSP began a recruitment fair to hire 10 Public Health Investigation Trainees.

Perinatal

During this report period, LAC applied for IRB continuations and received approval letters from several pediatric HIV-specialty hospitals, including UCLA, Kaiser-Bellflower, LAC+USC, Miller Children's Hospital Long Beach (LBMMC), Harbor-UCLA, and Children's Hospital Los Angeles (CHLA) to identify and report infants born to HIV-positive women at these LAC facilities. From January to December 2016, 95 HIV-exposed infants were reported to DHSP and identified as having received care and treatment in LAC. Of this group, 76 were born in 2016.

Establishing good working relationships and conducting data abstractions at multiple medical facilities in one of the geographically largest counties in the United States require an extensive amount of time, coordination, and manpower. To evaluate the progress toward maximal reduction of perinatal HIV transmission in LAC, pediatric surveillance staff continue to routinely visit all IRB-approved, pediatric HIV-care facilities to identify and report all infants born to HIV-infected mothers in 2016. With the hiring of a new MRA and after some training and practice, Ms. Danzig has successfully conducted all 70 medical record reviews and abstractions for the backlog of cases from all EPS sites for the 2015 birth cohort year. In addition, 68% (52/76) of all medical record abstractions for the 2016 birth cohort year have also been completed. With major remodeling taking place at the LAC+USC Medical Records Department in 2016, Ms. Danzig has recently been granted access to the LAC+USC Maternal, Child & Adolescent Clinic to conduct electronic medical records reviews, therefore, abstractions at LAC+USC will soon be back up to speed and caught up. The efficiency and timeliness of reporting new perinatally-exposed cases, born during the second half of 2016, have also increased.

Most recently in December 2016, our Data and Surveillance Workgroup for the CDC-sponsored Elimination of Mother to Child HIV transmission (EMCT) Stakeholders' group, received notification from Public Health Reports that their manuscript entitled, *Perinatal HIV Exposure*

Surveillance and Reporting in the United States in 2014, was finally published. This long and challenging manuscript was developed in response to the findings from a survey targeting all states and jurisdictions in the U.S. to determine how many sites collect data on perinatal HIV exposures, describe perinatal HIV exposure surveillance activities, assess facilitating factors, technical assistance needs and resources, and how barriers (if any) were overcome to start or enhance state perinatal HIV exposure surveillance. As Co-Chair of the Data and Surveillance Workgroup, Ms. Naghdi helped present the final data results from the survey via a CSTE-sponsored webinar in February 2016. In July 2016, Ms. Naghdi also attended the annual EMCT Stakeholders group meeting in Washington D.C. During the annual meeting, ongoing work on the future of perinatal HIV prevention activities was discussed, including HIV diagnostics, engaging partner and determining HIV status in the perinatal setting, and perinatal HIV surveillance coordination and collaboration across programs to support the framework for elimination. Additionally, another important action item the group has been pursuing deals with the development of a technical guidance protocol for birth registry matches with vital statistics. The goal is for jurisdictions to be able to identify *all* babies born to HIV-positive mothers and, therefore, be able to obtain a true perinatal transmission rate. A more complete ascertainment of all HIV-exposed infants would allow for a more accurate "picture" of perinatal HIV exposure and transmission in each jurisdiction.

Condom Distribution:

We were able to successfully coordinate condom and PrEP outreach at many LGBT pride events, as well as other outreach events in order to enhance the message that there are many ways individuals can protect themselves from HIV. For Calendar Year (CY) 2016, a total of 4,163,950 condoms were distributed.

Policy Initiatives:

We have been able to implement a standardized process by which community medical providers and public health staff can access needed information from HIV surveillance for purposes of continuity of care, as allowed under CA state law (as of 2011). We also implemented our PrEP implementation plan as described above.

3. Describe the **challenges** experienced with implementing your HIV prevention program for each of the four required core components funded under Category A during the reporting period. Please specify the program component associated with the challenges. What plans or actions have been taken to address the challenges?

HIV Testing (Non-Healthcare Settings):

For the reporting year 2016, LAC conducted a total of 65,636 HIV test events primarily within non-healthcare settings, with a positivity rate of 0.77% (508/65,636) for newly diagnosed HIV-positive individuals. This positivity rate is below the FOA requirement of 1.0%.

In response to the above, our initial findings show that the decrease appears to be due to fewer new positives being identified through the Mobile Testing Unit program. One agency/program that historically identified a large number of new HIV cases had their MTU out of commission for six months. Another agency/program which contributed about 60% of the testing volume among MTU and increased its testing volume by 33% in 2016 compared to 2015, saw a decrease in the positivity rates among MTU sites which previously had higher positivity rates. In 2016 this program only had 2 sites that had a new positivity rate >= 1.0%. However in 2015, this same agency/program had 15 sites with a new positivity rate of >=1.0%. The same pattern can be seen in several of the high volume mobile testing programs.

In addition, for agencies that conducted testing programs in both non-healthcare and healthcare settings, very few of the sites where testing was provided in a healthcare setting had a newly diagnosed positivity rate >= 1%. In 2016, there were only a few exceptions where targeted testing in healthcare sites was successful. Three of the nineteen programs had a newly diagnosed positivity rate averaging >=1.0%

DHSP will continue to investigate why the new positivity rate did not reach the FOA requirement. For the agency/program whose MTU was out of commission, the MTU is back in full operation.

Linkage to Care

There was a slight decrease in the successful linkage to medical care from storefront (77%) and social network (72%) sites within 90 days of the positive HIV test. During the first part of the year, a couple of the MTU programs experienced increased linkage to care rates, but this success did not translate to all of the MTU programs; MTUs in total achieved a 64% linkage to care of new HIV-positive testers identified. The challenge to achieving a linkage to care of 85% for all programs, and particularly for MTU programs, is the inability to transport clients who test HIV-positive to clinics outside of the clinic business hours. This increases the probability of losing newly diagnosed clients who test at night or during the weekend. This is the same barrier that the commercial sex venue (CSV) program faces, given that the testing hours for that program are late night and weekends.

DHSP Mobile HIV/STD Testing Unit

DHSP experienced significant set-backs with the operation of our mobile testing unit. The van required substantial repairs, which proved to be cost prohibitive. Ultimately, the decision was made to retire the vehicle rather than supporting ongoing maintenance to keep it functioning and on the road. In the interim, DHSP plans to collaborate with another internal DHSP team that has recently purchased a new MTU. This will allow DHSP to respond as appropriate to community requests, assess overall need and burden of disease among populations being tested, and provide the needed HIV/STD services.

Since the DHSP MTU was not operational, the team began providing storefront testing services in South Los Angeles. DHSP explored a new collaboration with the City of Los Angeles' gang reduction program that was setting up offices inside low income housing areas. This was challenging, as the gang reduction staff were new to their work, had trouble integrating our services, and provided no referrals or promotion of our services to the program participants. Safety concerns also hindered the program. Other options on how to improve this relationship are being considered.

Comprehensive Prevention with Positives:

RRA

Through their efforts later in the year, the Prevention with Positives programs reported a slight increase in the ability to recruit clients to their program who have been recently diagnosed and/or are out of care. The work that these programs conducted in partnering with HIV testing programs and conducting outreach seems to have had some benefit. Peer support continues to be a key component of these programs, as this has proven to be helpful in assisting newly diagnosed clients enter a new system of care that can be confusing and rigid. Data entry into the Evaluation-Web system by providers continues to be a challenge, because they do not have dedicated data-entry staff, thus delaying the entry of these service data into the system.

Partner Services

Partner Services activities are challenged by the volume of HIV and STD priority cases and separate HIV and STD Surveillance systems.

Perinatal

Unfortunately at this time, because there is still no mandated perinatal HIV-exposure reporting in the State of California, the capacity to monitor the epidemic locally remains challenging. Perinatal HIV-exposure reporting is essential to accurately calculate perinatal transmission rates, in order to monitor progress toward elimination of perinatal HIV transmission and to allocate appropriate resources. Mandated perinatal-exposure reporting in California is critical to support the National HIV/AIDS Strategy (NHAS) goal to reduce incidence of new HIV infections among infants by 25%. Unfortunately, without a reliable denominator or plans to suggest that the California Department of Public Health will conduct another Survey of Childbearing Women (SCBW) in the near future, it is difficult to assess our surveillance system for completeness of case ascertainment for the 2016 diagnosis year. Overall, since the EPS project first began in 1999, the total number and percentage of HIV-exposed and infected children reported to EPS have declined around 25% from 100 HIV-exposed cases reported at the initiation of the project to only 76 cases in 2016. We need to further investigate whether this decline is a result of medical advances in HIV testing and treatment and/or due to limited access to conduct perinatal HIV-exposure reporting in LAC.

Due to obstacles facing staff when conducting perinatal HIV surveillance, a position statement on perinatal exposure reporting in California has been written advocating for changes to the state HIV reporting regulations. These efforts will include contacting state legislators to sponsor a bill or an amendment to the existing HIV reporting regulation, in collaboration with DHSP's Chief of Staff and Director of Government Relations. However, due to continued staffing shortages and other priorities facing DHSP, our efforts have been stalled. The current Medical Director for DHSP, Dr. Sonali Kulkarni, will be advocating for changes to the California HIV reporting regulation. Additionally, Ms. Naghdi has also been trying to contact the California State Office of AIDS Surveillance Chief to discuss Section IX of the new Adult HIV Case Report form (ACRF) and its relevance to perinatal exposure reporting. Since the ACRF already asks for the name of the HIV-positive mother's child, their date of birth and hospital of birth, it appears as if perinatal HIV exposure reporting may be permitted. We would like to seek clarification with regards to laws permitting perinatal HIV exposure reporting in California. Unfortunately, due to high staff turnover, it has been difficult to find the right person to discuss these questions with at the California Office of AIDS. The current IRBs are in place at only seven facilities and, therefore, allow DHSP to capture only a subset of the perinatally-exposed pediatric population in LAC. In order to provide timely identification and follow-up of HIV-positive mothers and their exposed infants, and ensure linkage to pediatric HIV specialists for diagnostic testing and monitoring of the infant's health status, it is critical to identify *all* HIV-infected mothers who give birth each year in LAC. The CDC, the CSTE, and the American Academy of Pediatrics (AAP) have all recommended universal HIV perinatal exposure reporting to monitor the number of women living with HIV giving birth each year, the number of HIV-exposed children, as well as the programs to prevent perinatal transmission. In addition, in order to calculate a true perinatal transmission rate for HIV, it is necessary for exposure reporting to be population based and not just facility based. Finally, CDC allocation for future funding of perinatal HIV exposure surveillance activity will rely on jurisdictions having the necessary statutes and regulations in place to perform perinatal exposure reporting activities.

Lastly, because of its size and large concentration of high-risk women, LAC has a sizeable number of HIV-infected women of childbearing age. With more than 150,000 births annually, 30% of all births in California, LAC expects more than 100 HIV-infected women to give birth each year. Our goal is that none of these infants become infected. During this report period, 76

HIV-exposed infants born in LAC were identified and zero perinatal HIV transmissions reported. However in 2015, LAC reported 70 HIV-exposed infants and 2 perinatal transmissions, representing a 3% transmission rate. These moms, with perinatal HIV transmission, struggled with mental health and/or substance issues and engaged in unsafe sexual practices. More prevention activities need to target how mental health and substance abuse issues affect women living with HIV and the impact on perinatal HIV transmissions. As of December 30, 2016, among 5,863 women living with HIV/AIDS in LAC, 2,312 (39%) were of childbearing age (15-44 years). This underscores the need for strategies to ensure that all HIV-infected females have access to adequate prenatal care, timely HIV counseling and voluntary testing, and access to HIV-related care and services.

Condom Distribution:

No significant challenges.

Policy Initiatives:

No significant challenges.

HIV Testing and Comprehensive Prevention with Positives

Note: Quantitative information for HIV testing for Category A in healthcare and non-healthcare settings, as well as aggregate testing data, will be reviewed via the PS12-1201 Data Tables that will be auto-populated with NHM&E data submitted via EvaluationWeb®. Quantitative aggregate data on Interventions and Services for HIV-Positive Individuals, submitted via EvaluationWeb®, will also be included in the PS12-1201 Data Tables. Please review these tables (template) for reference.

Partner Services

1. Provide information on Partner Services (PS) for this reporting period. **See Table 1 below.**

Table 1. Newly Diagnosed, Confirmed HIV-positive Index Patients[1]					
New HIV Cases Reported to HIV Surveillance Program[2]	Newly Diagnosed Index Patients Reported to Partner Services Program[3,4,5]	Newly Diagnosed Index Patients Eligible for Partner Services Interview[6]	Newly Diagnosed Index Patients Interviewed[7] n (%)	Partners Named[8]	Partners Named per Newly Diagnosed Index Patient Interviewed[9]
2,291	1,971	1,965	1,397 71.09%	431	0.31

[1] This table includes data for all partner services, regardless of funding source, not just those funded under PS12-1201.
[2] This is the number of new HIV case reports received by the health department surveillance program during the reporting period, based on date of report, rather than date of diagnosis.
[3] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period, from any source.
[4] New diagnosis status verified, at minimum, by cross-check with the health department surveillance system. Supplementary methods of identifying previous diagnosis, such as review of laboratory reports, medical records, or other data sources (e.g., partner services database, evidence of previous treatment for HIV), or patient interview, may also have been used. If any data source, including patient self-report, indicates previous diagnosis, diagnosis is not new.
[5] Does not include index patients classified as newly diagnosed based only on 1) self-report of having had no previous test or having had a previous negative test or 2) review of other data sources (e.g., medical records, partner services database, treatment database).
[6] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period (Column B), excluding those who are out of jurisdiction or deceased.
[7] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period and eligible for partner services interview (Column C), who were interviewed for partner services by the health department or a person trained and authorized by the health department to conduct partner services interviews.
[8] This is the total number of partners named for whom the information provided by the index patient or otherwise available should be sufficient to allow the partner to be identified and notified by health department partner services workers.
[9] This is the average number of partners named by the newly diagnosed index patients who were interviewed.

Calculations:

E = (D/C) x 100

G = F/D

Condom Distribution

1. Provide the total number of condoms distributed overall (to HIV-positive individuals and high-risk HIV-negative individuals) during the reporting period.

Total number of condoms distributed overall: 4,163,950

Policy Initiatives

1. What policy initiatives did you focus on during the reporting period? Please indicate the type/level of intended impact for each policy initiative (e.g., change on a local level, health department level, or statewide/legislative level) as well as the stage of the policy process (e.g., identification, development, implementation, evaluation). Please also indicate if any are new policy initiatives. If no policy initiative was focused on during the reporting period, please explain.

The focus of our policy efforts in 2016 revolved around biomedical prevention, specifically the implementation of our local LAC PrEP strategy, which revolves around three goals: increasing consumer awareness of PrEP, 2) increasing provider awareness and use of PrEP, and 3) creating a safety net access system for PrEP. We successfully developed and rolled out a PrEP social marketing campaign, trained numerous medical providers through CMEs and technical assistance, and contracted with 9 agencies with 13 clinics to provide PrEP to low income individuals at elevated risk of HIV. This will greatly expand the number of individuals who receive comprehensive prevention education and HIV testing on a regular basis, in addition to PrEP or PEP.

2. Please indicate if the following occurred during this reporting period:
   Did you make any updates to the current HIV Outbreak Response Plan? ☐ Yes ☒ No
   Did you identify any emerging HIV infections in populations/areas within the jurisdiction, as a result of having an HIV outbreak response plan in place? ☐ Yes ☒ No
   If yes, please provide a brief update.
   Did you identify any emerging HIV infections in populations/areas within the jurisdiction, as a result of participating in molecular HIV surveillance? ☐ Yes ☒ No
   If yes, please provide a brief update on any follow-up prevention activities (e.g., Partner Services) to support this activity.

We have utilized our linkage and reengagement staff (similar to Partner Services staff) to link newly diagnosed cases and virally unsuppressed cases to care for two separate transmission networks identified by CDC's molecular surveillance team. However, we have not identified any emerging HIV infections as a result of this activity, and we did not do aggressive partner elicitation and notification because of the time delay. Our hope is that as this process becomes routinized at CDC and we can find out the information closer to real-time, we'll be better positioned to do linkage plus partner services for these cases.

CATEGORY A: Recommended Components
Please indicate which recommended components were implemented during this reporting period.
If none, please select "None" and continue to the Required Activities section.

☒ Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals
☒ Social Marketing, Media and Mobilization
☒ PrEP and nPEP **(Through a combination of funds)**
☐ Syringe Services Program
☐ None

Please provide responses to the following questions for the recommended components for Category A, if implemented. Responses to questions should cover all three recommended components.

1. Describe any **substantial changes** made to your HIV prevention program for the recommended components funded under Category A during the reporting period. Please describe the changes made for the specific program component.

Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals:

No substantial changes were made during the reporting period. DHSP anticipates that new prevention programs targeting young African-American and Latino men who have sex with men and Transgender Individuals will begin in 2017. At the time of this report, the solicitation process was concluding negotiations with nine successful proposers.

Community Level Interventions

As reported in the APR, a new contractor to provide Faith-based HIV/AIDS Prevention Services within the African-American community was awarded a contract. Due to circumstances beyond our control, the identified contractor choose not to accept the contract after it was fully executed. Hence, these services were not implemented during the second half of the reporting period as previously planned. The current faith based provider targeting Latino communities of faith continues to conduct community level interventions and are currently creating relationships with African-American faith leaders to assist with the implementation of these interventions.

Social Marketing, Media, and Mobilization:

We successfully launched a social marketing campaign for PrEP and PEP that integrates well into our existing condom campaign. We plan to integrate treatment as prevention into the campaign in 2017.

PrEP and nPEP:

2. Describe the **successes** experienced with implementing your HIV prevention program for the recommended components funded under Category A during the reporting period. Please specify the program component associated with the successes.

Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals:

Through CDC PS15-1506, we successfully launched our PrEP strategy to increase PrEP awareness, use and access.

Programs targeting high-risk HIV-negative individuals continue to see steady participation in the various program interventions. The programs are implemented in both an individual-level and group-level format. Staff of these programs have attended several PrEP- information workshops that result in the exchange of correct information to their clients, thus increasing the interest in high-risk clients to consider the use of PrEP. Additionally, these programs continue to successfully link clients to HIV and STD testing and treatment.

Social Marketing, Media, and Mobilization:

In 2016, we launched "The Protectors" campaign, which is playful and appealing to young adults, and has the potential to easily integrate multiple prevention messages. See our website getprepla.com. We had a very successful debut of our campaign at multiple LGBT pride events in the community and have become a known presence at many community health forums.

PrEP and nPEP:

We conducted numerous medical provider trainings, implemented PrEP in our STD clinics, and launched our safety net system of PrEP Centers of Excellence, which offer PrEP and PEP to low income individuals in LAC.

3. Describe the **challenges** experienced with implementing your HIV prevention program for the recommended components funded under Category A during the reporting period. Please specify the program component associated with the challenges. What plans or actions have been taken to address the challenges?

Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals:

Interventions that require attendance at several sessions continue to be challenging for these programs. The retention of participants in multi-session group series is challenging, especially when competing with other priorities that include employment, school and social engagements. These programs have adapted to these challenges by offering group sessions late in the afternoon, and/or on evenings and on weekends. They also continue to incorporate a holistic approach to addressing client's needs by referring clients to mental health, substance abuse treatment, vocational training, etc.

Social Marketing, Media, and Mobilization:

No significant challenges.

PrEP and nPEP:

No significant challenges.

Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals
☐Not applicable

1. Did you support evidence-based HIV prevention interventions for high-risk HIV-negative individuals during the reporting period?
   ☒ Yes ☐ No
   If yes, briefly describe which populations and what activities were supported.

HIV prevention interventions for high-risk HIV-negative individuals were delivered to men who have sex with men, transgender individuals and the Latino faith community. Interventions included individual-level, group-level and community level activities. Services were provided in

various venues that included community centers, clubs, parks and places of worship. Issues addressed in these interventions ranged from information related to PrEP and PEP access and acceptability, insurance coverage, HIV and STD screening and treatment, condom negotiation, and communication with partners about sexual risk taking. Documented referrals to HIV testing, STD screening, and substance use treatment.

Note: Quantitative aggregate data on Interventions and Services for High-Risk HIV-negative Individuals, submitted via EvaluationWeb®, will be included in the PS12-1201 Data Tables. Please review these tables (template) for reference.

Social Marketing, Media and Mobilization

☐ **Not applicable**

1. Did you promote and/or support a CDC social marketing campaign during the reporting period?
   ☒ Yes ☐ No
   If yes, please indicate the specific CDC social marketing campaign.

DHSP continues to utilize materials developed through the "Let's Stop HIV Together", the Latino MSM campaign "Reasons/Razones", and "Testing Makes Us Stronger". Materials are shared internally and with providers to distribute during testing events, outreach activities, health fairs, and in mobile testing units.

Pre-exposure Prophylaxis (PrEP)

☐ **Not applicable**

1. Did you provide services to support PrEP for high-risk populations during the reporting period?
   ☒ Yes ☐ No **(through CDC PS15-1506)**
   If yes, briefly describe which populations and what activities were supported.

Using our PS15-1506 CDC PrIDE funding, we implemented our local LAC PrEP strategy, which revolves around three goals: 1) increasing consumer awareness of PrEP, 2) increasing provider awareness and use of PrEP, and 3) creating a safety net access system for PrEP. We successfully developed and rolled out a PrEP social marketing campaign, trained numerous medical providers through CMEs and technical assistance, and contracted with 9 agencies with 13 clinics to provide PrEP to low income individuals at elevated risk of HIV. The target populations for these

activities in 2016 were African American and Latino MSM and transgender men and women. For 2017, we will be trying to reach more high-risk heterosexual women.

Non-occupational Post-exposure Prophylaxis (nPEP) Services
☐ **Not applicable**

1. Did you provide services to support nPEP for high-risk populations during the reporting period?
   ☒ Yes ☐ No
   If yes, briefly describe which populations and what activities were supported.

Our nPEP activities have been integrated completely into our PrEP related activities. Our providers do both PrEP and PEP. In addition, we have been working with our local PrEP workgroup to do more targeted outreach and education about PEP to emergency room and urgent care providers.

Syringe Services Program (SSP)
☒ **Not applicable**

1. Did you submit a determination of need (DON) for SSP? ☐ Yes ☐ No
   If yes, did you redirect funds for 2016? ☐ Yes ☐ No

2. Did you provide services to support SSP for high risk populations during the reporting period?
   ☐ Yes ☐ No
   If yes, briefly describe which populations and what activities were supported.

CATEGORY A: Required Activities
All three required activities should be conducted during this reporting period.

☒ Jurisdictional HIV Prevention Planning
☒ Capacity Building and Technical Assistance
☒ Program Planning, Monitoring and Evaluation, and Quality Assurance

Jurisdictional HIV Prevention Planning

1. Did you make any changes to your HIV planning group (HPG) to realign with the new Integrated HIV Prevention and Care Plan Guidance during the reporting period (e.g., changes in composition or structure, bylaws, frequency of meeting, etc.). If yes, please describe the changes made. **Please provide the membership profile information for your HPG. See Appendix B.**

Strengthened COH Membership and Skills

The Commission on HIV (COH), the local HIV community planning body, under the leadership of the Operations Committee, scaled up its efforts to strengthen the skills of members in order to better align with the new Integrated Plan guidance.

- Filled 92% of the COH seats, with continuing recruitment efforts to fill remaining vacancies.
- Conducted a comprehensive 3-hour New Member Orientation training for new members.
- Completed an electronic COH Member Manual and a 2017 training series for Commissioners to increase community planning knowledge and skills.
- Conducted community outreach events, reaching over 100 community members, to promote the work of the COH and educate the community about HIV/STD services in LAC.
- While no changes to bylaws were made, the Operations Committee reviewed and updated 10 policies and procedures related to membership and meeting management.

2. Describe the **successes** experienced with implementing your HIV prevention planning activities during the reporting period.

Improved Planning for Community Health

The COH used the Comprehensive HIV Plan as the driving document to guide its priorities and planning activities.

- Completed the Los Angeles County Comprehensive HIV Plan (CHP) 2017-2021, the County's second integrated HIV services plan road map for achieving the goals of the National HIV/AIDS Strategy 2020 (NHAS). This plan was developed in partnership with DHSP and innumerable community and organizational partners. It presents a blueprint for HIV services along the entire spectrum of HIV prevention and care.
- Upon approval of the CHP, COH committees reviewed the CHP and integrated specific activities most relevant to their functions. For example, the Priorities, Planning and Allocation Committee used the CHP to help inform the update of the Minority AIDS Initiative Plan, Program Directives, and prevention planning efforts; the Standards and

Best Practices Committee used the CHP to revise and update the Comprehensive HIV Continuum and started preparing for the development prevention service standards; the Operations Committee created a training plan to ensure planning council members have the skills necessary to successfully fulfill their duties as community planners.

- The updated Comprehensive HIV Continuum better integrates prevention and recognizes the role that social determinants of health play in driving the acquisition and transmission of HIV. The Comprehensive HIV Continuum serves as a key planning tool in developing service standards for HIV/STD services in LAC.
- Completed seven community listening sessions as part of the COH's ongoing community needs assessment to better understand the barriers to services faced by populations most impacted by HIV/AIDS and STDs
- Hosted second annual Trans Health Summit, providing a safe space and educational forum for providers and the trans community to discuss and address HIV, STD and health issues unique to this underserved population

3. Describe the **challenges** experienced with implementing your HIV prevention planning activities during the reporting period. What plans or actions have been taken to address the challenges?

The recruitment of a State Medicaid (Medi-Cal) and a recently incarcerated individual continues to be a challenge. The Executive Director will continue to work with the Operations Committee and other partners to secure representatives for these seats. The recruitment of younger consumers (18-29 years) has been a challenge. To mitigate this challenge, the Youth Caucus disseminated social media invitations to their peers to attend the COH meetings to encourage participation and provide public comments on youth-related HIV issues.

Capacity Building and Technical Assistance (CBA/TA)

1. Did you access CBA/TA services during the reporting period? ☒ Yes ☐ No

2. **Note:** CBA provided via CDC-funded providers will be pulled via CRIS. However, please explain (be specific) if any of the CBA/TA provided did not meet your needs/expectations. **N/A**

3. Please provide the type of CBA/TA received and the name(s) of CBA/TA provider(s) for any **non-CDC provided CBA to include training provided by your internal training unit (if applicable).**

As part of our training portfolio, DHSP's Quality Management team provides training and capacity building to DHSP contractors. See Attachment 1 for a listing of trainings offered in CY 2016.

Program Planning, Monitoring and Evaluation, and Quality Assurance

1. Did you make any **substantial changes** to your program planning, monitoring and evaluation, and quality assurance activities during the reporting period?
   ☐ Yes ☐ No
   If yes, please describe the changes made.

Program Planning

Linkage and Re-engagement Program

During 2016, DHSP made significant strides in developing and implementing data to care programming. The Linkage and Re-engagement Program (LRP) which is funded by HRSA, was officially launched in the spring of 2016 and affected changes within the County by offering a new service for clinics and other community partners to refer for clients lost to care and for newly diagnosed clients who have never been linked to a medical provider.

LRP trained staff to use surveillance and other data systems to identify clients and to develop important partnerships with high risk social networks, medical clinics, Medical Care Coordination teams, and the jails. Critical collaborative working relationships were established during this phase of the program.

Quality Assurance (QA)

During this reporting period, there were no substantial changes to the Quality Assurance activities. DHSP's Clinical and Quality Management (CQM) team continues to focus efforts on maintaining high levels of service quality offered directly and through our supported partners. Clinical and Quality Management is charged with training, ongoing competencies and proficiencies, monitoring testing site quality assurance activities, responding to grievances and incidences, and compiling and analyzing data.

DHSP partnered with the Gang Reduction & Youth Development (GRYD) Foundation to provide HIV/STD testing and prevention services. Initially the focus of these services was on winter shelters and recreational centers for homeless youth located within communities of government assisted residences. Testing and prevention services continued beyond the winter months and continue to expand to additional sites. As these sites are identified, DHSP's CQM team works closely with DHSP's Contracted Community Services team to develop HIV/STD testing services tailored to meet the needs of each site.

Testing Technologies

DHSP continues to evaluate several new testing technologies in order to expand services offered to LAC residents. The Determine HIV-1/2 Ag/Ab Combo, a 4th generation rapid point of care CLIA waived test, is being added to DHSP's options of testing devices. During this reporting period a training curriculum was developed and piloted with DHSP's surveillance team. DHSP continues the process of developing additional protocols and quality assurance guidelines to better equip community partners in the development of quality testing services.

As previously reported, barriers which have delayed the rollout of this 4th generation rapid test to DHSP-supported agencies have largely been resolved. The curriculum was completed along with piloting it to select DHSP staff. Also, during the latter part of 2016, a contract with the vendor had been secured.

In addition to rapid HIV tests, DHSP continues to explore ways to provide rapid point of care syphilis testing and rapid point of care hepatitis C testing. As preparations are underway in developing the policies, procedures and quality assurance guidelines, the capacity to support and implement these technologies will continue to be explored in 2017.

DHSP had collaborated with LA County Department of Health Services (DHS) for more than 2 years to assist their Family Planning Clinical Program to implement opt-out testing in their Title X clinics to test patients at risk for STDs and pregnancy for HIV using rapid testing. Title X is the only federal grant program dedicated solely to providing individuals with comprehensive

family planning and related preventive health services. The program (DHS' Women's Health and Innovation program) had expanded to three women's clinics located at Hubert H. Humphrey Comprehensive Health Center, H. Claude Hudson Comprehensive Health Center and Harbor-UCLA Medical Center. However, as of August 30, 2016, their focus and funds were re-directed to other services and resulted in discontinuation of their HIV testing initiative. During a 26-month period the program tested over 5,500 patients.

A deficiency assessment was conducted on CQM's internal procedures and revealed a lack of standard procedures among the team members providing quality assurance oversight to supported testing programs. During this reporting period collaborative efforts between Clinical and Quality Management's Quality Assurance (QA) team and the Provider Support Services team began developing a comprehensive protocol for conducting Competency Assessment Testing (CAT) and testing site quality assurance assessments. This protocol will document in detail all the processes and steps involved when the QA team conducts site visits to the affected agencies. It is anticipated the protocol will be completed early in calendar year 2017.

DHSP's CQM team also continues to assist community partners who are not directly supported by DHSP but get their support from other sources. DHSP supports all efforts in Los Angeles County for HIV/STD prevention, screening and linkage to care and treatment, and therefore, offer its expertise to organizations seeking to provide these services. Three such agencies with whom DHSP's CQM section has met to discuss planning, implementing and evaluating phases of developing an HIV testing program are Black AIDS Institute, Claris Health and Via Care L.A. (formerly Bienvenidos). As agencies progress in their testing program development, CQM's team of PHNs/RNs continue to provide direction and technical assistance along with agency staff trainings to facilitate the agency's Quality Assurance Plan development.

2. How are you using the most current epidemiologic and surveillance data for program planning, implementation, and evaluation purposes during the reporting period (i.e., data to care)? Include the types of data used. How are you disseminating your program monitoring and evaluation data and providing feedback to your healthcare and non-healthcare providers and other community partners? If the surveillance team is receiving updated information (e.g., updated risk, residence, contact, or linkage status information) from program staff, please explain what data and how it helps surveillance (e.g., surveillance data are more up to date and accurate).

Use of HIV Surveillance Data for Program Planning

DHSP uses surveillance data to plot the entire continuum of HIV for LAC. Surveillance data are used to identify geographic areas of LAC with increased or increasing HIV and STD burden, identify specific target populations with increased proportion of seropositivity, and identify previously diagnosed persons who are not currently linked to medical care, in order to develop and place programs where the need is greatest. These data inform program planning. For example, LRP is a DPH-based program that focuses on locating people living with HIV in LAC who are HIV-positive and 1) never linked into HIV care, or 2) who 'fell' out of care, in order to link or re-engage them into consistent and appropriate HIV medical care. LRP was developed using the best practices and lessons learned from previous demonstration projects conducted by DHSP that tested new and innovative strategies to identify out-of-care PLWH in order to link and re-engage them in primary HIV medical care, including the use of surveillance data to initially identify HIV-positive clients who were not in HIV medical care.

Dissemination of Program Monitoring and Evaluation Data

As a large urban health department, DHSP manages both the HIV/AIDS surveillance system (HARS) and the STD surveillance system (STD NETTS). In addition, DHSP obtains data directly from DHSP-funded HIV and STD programs via electronic transfer, scanning, or manual data entry. Data are collected from non-contracted HIV testing sites such as independent health departments within LAC, directly funded CDC testing programs, and large agencies or healthcare settings in the Los Angeles area. These data populate DHSP's HIV Testing database and care services Casewatch system. To complement these data systems, DHSP also securely stores a number of datasets such as: needs assessments (e.g., Los Angeles Coordinated HIV Care Assessment (LACHNA) and LACHNA-Care), original epidemiologic studies, demonstration projects, and research projects. These data in totality assist DHSP in planning, evaluating, and conducting quality assurance to maximize prevention, care and treatment efforts in LAC.

DHSP has improved data dissemination by increasing the use of its website and the automation of reports. DHSP staff have automated a number of reports (e.g., monthly HTS reports, quarterly HTS reports, exit interview contractor monitoring reports, quality management reports, partner services activities reports, etc.) that expedite monitoring, evaluation, and planning activities.

These reports are available to and utilized by DHSP grants management team, research and evaluation staff, contract program auditors (program managers), quality management staff, and contractors. Reports are posted on the DHSP website (e.g., Care Utilization Report, HTS Annual Report, HIV Epidemiologic Profile, HIV/AIDS Annual Surveillance Report, STD Annual Report, Book of Maps, etc.), while other data or results are shared in meetings, local conferences or workgroups, national conferences, and in published manuscripts. For example, HTS data are presented to all DHSP contracted HTS providers at regular meetings; data and findings are shared with community planning groups, Medical Advisory Committee, DPH Annual Science Summit participants, ESRI (GIS software related), and at numerous local and national conferences. In addition, DHSP disseminates data results and key findings with CDC project officers and other representatives during site visits. In order to increase data dissemination, DHSP plans to create more automated reports, continue to update and populate the new integrated HIV and STD website, create and post project abstracts/profiles, and increase the number of published manuscripts.

SECTION II: CATEGORY B: Expanded HIV Testing Program

Please indicate which Category B components were implemented during this reporting period. *If none, please select "None" and continue to the Staffing and Management section.*

☒ HIV Testing in Healthcare Settings (required)
☐ HIV Testing in Non-healthcare Settings (optional)
☐ Service Integration (optional)
☐ None

Currently, 24 healthcare settings are funded or supported by DHSP to provide routine, opt-out HIV testing.

- Twelve Department of Public Health STD Clinics
- One Community STD Clinic (Los Angeles LGBT Center)
- Three Comprehensive Health Centers (Hubert H. Humphrey Comprehensive Health Center, H. Claude Hudson Comprehensive Health Center, and Harbor-UCLA Medical Center)
- Four Community Health Centers (THE Clinic, Clinica Oscar Romero, Central City Community Health Center, and St. John's Well Child Family Center)
- One Dental Clinic (USC School of Dentistry)
- One Emergency Department (LAC+USC Medical Center), and
- Two Jails/Correctional Facilities (K6G and CRDF)

Please provide responses to the following questions for your funded Category B HIV testing program. Responses to questions should cover all funded components.

1. Did you make any **substantial changes** to your expanded HIV testing program in healthcare settings and non-healthcare settings, including service integration? If yes, please describe the changes made.

HIV Testing in Healthcare settings:

Under Category B, 100% of testing is taking place within healthcare settings. For testing in non-healthcare settings, see Section I: Category A: Required Core HIV Prevention Program- HIV Testing.

Contracted Non-County clinics

There were no substantial changes for the reporting period.

Comprehensive Health Centers

As reported earlier, DHS' program had expanded HIV testing to three women's clinics located at Hubert H. Humphrey Comprehensive Health Center, H. Claude Hudson Comprehensive Health Center and Harbor-UCLA Medical Center. However, as of August 30, 2016, their focus and funds were re-directed to other services and resulted in discontinuation of their HIV testing initiative.

DPH STD Clinics

We did not make any significant changes to our routine testing program.

Jails/Correctional Facilities

Men's Central Jail (MCJ-K6G)

DHSP counselors continue to offer comprehensive HIV/STD testing to all inmates housed in the K6G unit at Men's Central Jail including HIV, syphilis, chlamydia and gonorrhea. Despite working with a challenging population, DHSP staff conduct active outreach to educate and encourage inmates to test and also provide them with condom distribution. Staff also continue to maintain a close collaboration and working relationship with the Los Angeles Sheriff's Department (LASD) to ensure deputies are aware of the importance of the public health services being provided.

Century Regional Detention Facility (CRDF)

DHSP staff continue to offer HIV testing in the housing pods at CRDF to all inmates. Due to the high rates of STDs in this population, we have recently begun to examine the feasibility of adding testing for gonorrhea and chlamydia to this program. While DHSP currently offers gonorrhea and chlamydia screening and testing to all females at intake in the Inmate Reception Center, the environment poses additional challenges to universal implementation. Offering these tests in the housing pods as well would provide an opportunity to target any individuals that were missed during the booking process.

HIV Testing in Non-healthcare settings: N/A
Service integration: N/A

2. Describe the **successes** experienced with implementing your HIV testing program in healthcare settings and non-healthcare settings, including service integration, during the reporting period.

HIV Testing in Healthcare settings:

DHSP's goal for routine testing in healthcare settings was to conduct 60,000 HIV test events for 2016 and to identify 588 newly identified HIV-positive individuals. At the end of the year, LAC is reporting 87% (52,384/60,000) of our projected HIV testing goal for healthcare settings.

At the end of the year, 52,384 test events had been conducted with an HIV positivity rate of 1.11% (582/52,384) for newly diagnosed HIV-positive individuals. This positivity rate exceeds the FOA requirement of 0.10%.

Our routine testing providers continue to integrate testing into their clinical practice and serve as local champions. Our LASD jail medical leadership agreed to work to integrate laboratory based HIV testing into their existing clinic procedures by adding in a "flag" into their electronic medical record (EMR) so that providers ordering labs for any patient who hasn't had an HIV testing in the past 6 or 12 month would be reminded to order an HIV test.

Men's Central Jail (MCJ-K6G)

Given the demanding work environment of providing services in a correctional facility to incarcerated populations, staff are required to be resourceful and find creative solutions in order to work successfully with our LASD partners. It can be a challenge to combine the provision of essential public health services while ensuring public safety is not compromised. There is a high turnover of staff within LASD, therefore DHSP staff have to routinely educate new deputies to the importance of the services we provide. This includes meeting with LASD senior staff (Lieutenants, Captains and Commanders) and involving DHSP senior leadership to actively maintain open communication and understanding of processes and procedures used during testing.

LASD often requires that DHSP staff issue medical passes and wait while custody assistants transport inmates to the testing location. This can be very time-consuming and limits the number of inmates that DHSP can test daily. DHSP staff have established close relationships with the

deputies on the floor to be able to escort the inmates to the test location with the oversight of the deputies thereby making the procedure much more efficient for all parties involved.

Century Regional Detention Facility (CRDF)

DHSP closely examined and further streamlined the process for female inmates who have tested positive for STIs and are released without treatment. This included ensuring positive inmates were immediately identified and referred if still in custody, refining the procedure for follow-up in the community including establishing a clear contact log procedure and resolving all open cases in Casewatch for data quality management and reporting purposes.

DHSP has also improved communication and collaboration with nursing staff at CRDF by maintaining an active presence inside the correctional facility by all levels of managers. Supervisorial staff have taken the time, on numerous occasions, to meet in person with nursing staff to address issues such as storage constraints, laboratory reporting, faxing of lab results and other daily duties that have strengthened the relationship between DHSP and LASD to further enhance services being provided for the inmates.

HIV Testing in Non-healthcare settings: N/A
Service integration: N/A

3. Describe the **challenges** experienced with implementing your HIV testing program in healthcare settings and non-healthcare settings, including service integration, during the reporting period. What plans or actions have been taken to address the challenges?

HIV Testing in Healthcare settings:

Contracted Non-County Clinics

At the end of the reporting period, the majority of the programs experienced a reduction in the number of people being tested. Although, the higher performing program, such as the LGBT Center, continued to see an increase in the number of clients being tested. Most of the routine testing sites are general practice clinics, where there continues to be a reluctance by patients to accept an HIV test, even when it's made as part of a routine medical assessment.

County Facilities

We have struggled with bringing on routine HIV testing in two particular settings: 1) a large county ambulatory care center in a highly impacted part of LAC, and 2) our LASD Jails. For the ambulatory care center, we had multiple conversations with physician and administrative leaders but in the end, there was no single champion who was willing to see the process through to fruition. The issue of how HIV-positive results would be followed up was one that plagued the group as there was no existing system to build off of. For the LAC jails, we have not been able to work with them on fulfilling their agreement to implement the EMR flag to ensure more testing but hope to do so in 2017.

Men's Central Jail (MCJ-K6G)/Century Regional Detention Facility (CRDF)
DPH's Public Health Lab's (PHL) reporting system, which is used by DHSP testing counselors to collect and request specimen samples, underwent an upgrade this past year and all operating systems needed to be updated. This posed a significant challenge when interfacing with the security firewall at LASD. Staff faced numerous and time-consuming setbacks with implementation that resulted in using paper acquisitions to request lab results at times. Coordination of these technical services were required between PHL, DHSP IT and LASD IT, all agencies with offices in different physical locations lending an additional layer of complexity to the situation. However, all DHSP staff have now been trained, are familiar with the new system, and all operating systems have been cleared to be used inside the LASD firewall.

HIV Testing in Non-healthcare settings: N/A
Service integration: N/A

Billing Redirection

4. Please provide a brief update on progress made with the Category B billing redirection during this reporting period. Please include progress made on billing for HIV services, training, staffing, contracts, and needs assessment/business case analysis.

In late 2016, we utilized funds (including carryover) to continue the progress/work being made toward third party billing. Funds supported electronic medical record (EMR) implementation activities which are critical for third party billing. Phases covered this period were *Project Initiation and Planning*, development of the *Implementation Approach*, and completion of a Public Health Lab (PHL) study (*APHL LIMS Study*) to assess and determine costs, benefits, capability, gaps, risks, and mitigation plan if the LIMS is implemented at the County PHL.

Our public health STD clinic partners have been able to make tremendous progress planning for their EMR implementation in 2017. Once the EMR goes live, they will work with their consultant on implementing the billing infrastructure for certain clinic patients.

5. Please describe the **successes** experienced with implementing this sustainable HIV testing effort during this reporting period.

Our public health department leadership has been very supportive of EMR implementation and the thoughtful use of billing so as to increase overall revenue but not drive patients away.

6. Please describe the **challenges** experienced with implementing this sustainable HIV testing effort during this reporting period. What plans or actions have been taken to address the challenges?

We still have not been able to outline how billing will be implemented and how we will avoid driving away patients who are used to seeking HIV/STD services in our STD clinics specifically for the confidentiality (that may be limited in a billing environment where patients receive a statement of evidence of benefits for anything their insurance pays for).

HIV Testing in Healthcare Settings *(required)* and Non-Healthcare Settings *(optional)*
Note: Quantitative information for HIV testing for Category B in both healthcare and non-healthcare settings, as well as aggregate testing data, will be reviewed via the PS12-1201 Data Tables that will be auto-populated with NHM&E data submitted via EvaluationWeb®. Please review these tables (template) for reference.

1. Please indicate if any of the funded healthcare settings/providers within the jurisdiction were able to utilize 3rd party reimbursement and/or bill for HIV testing. **See Table 2 below.** Estimate the percentages of total test events in healthcare and non-healthcare (*if applicable*) settings that were paid for by PS12-1201 Category B funds, by 3rd party reimbursement, and by other funds. If other funds were used, please specify the source of those funds (e.g., state funds).

Table 2. Estimated Percentages of Test Events Paid for by PS12-1201 Category B Funds, by 3rd Party Reimbursement, and by Other Funds.

Funding Source	Estimated Percent of Test Events	
	Healthcare Settings	Non-Healthcare Settings
PS12-1201 Category B	100%	N/A%
Medicaid	0%	N/A%
Private Insurance	0%	N/A%
Other (please specify)		
▪	%	%

SECTION III: STAFFING AND MANAGEMENT

1. Please indicate any organizational and/or key staffing changes (i.e., health department staff responsible for implementing interventions and services for PS12-1201) that occurred during the reporting period. Please indicate any vacant staff positions and provide a detailed plan with timeline for hiring/filling vacancies. Were there any delays in executing contracts during the reporting period? If so, please explain and include any program implications.

For 2016, there were no key organizational or staffing changes. Although DHSP continues to experience delays in filling a majority of its vacant positions, we have made progress in filling most of our long term vacancies by emphasizing recruitment, exam postings and interviews for these positions. However, there are still a number of other factors that are causing delays in DHSP filling all of its vacant positions. Also, due to grant funding limitation for this federal program, DHSP identified most of its vacant positions on the budget as In-Kind and not grant funded.

In early 2017, CDC requested information on vacant positions for Category A & B. DHSP provided the status of vacant positions and estimated hire dates.

SECTION IV: RESOURCES ALLOCATION

Category A:

1. Include the percentage of Category A funding resources allocated to the required and recommended program components for Year 5 (2016). ***Note:*** *Percentage should be inclusive of both internal health department expenses (e.g., personnel and administrative cost) as well as funding resources being allocated external to the health department for the required and recommended components.* ***Percentages for required and recommended components including SSP should total 100%.***

   Year 5 (2016):

Required components:	80%
Recommended components:	20%
Total:	100%
SSP (if applicable):	0%

2. Please identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For directly-funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at

least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease. **See Appendix A: Resource Allocation.**

Category B:

1. Include the percentage of Category B funding resources allocated to HIV testing in healthcare settings and non-healthcare settings for Year 5 (2016). ***Note:*** *Percentage should be inclusive of both internal health department expenses (e.g., personnel and administrative cost) as well as funding resources being allocated external to the health department for the required and optional components.* ***Percentage for healthcare settings and non-healthcare settings should total 100%.***

Year 5 (2016):

HIV testing in healthcare settings:	100%
HIV testing in non-healthcare settings:	0%
Total:	100%

Billing Redirection: 19%

All Categories:

1. Please provide information for the funding allocation tables for 2016.

Note: The PS12-1201 funding table template for 2016 is included in EvaluationWeb. The 2016 information is due by March 15, 2017.

SECTION V: CERTIFICATION OF NHM&E DATA SUBMISSION

1. As a part of the PS12-1201 Cooperative Agreement, in addition to the submission of the progress reports to CDC, grantees must also submit the required National HIV Monitoring and Evaluation (NHM&E) data variables, through the CDC-approved system (i.e., EvaluationWeb®) and commit by the designated due date.

   Please certify below:

   ☒ We certify that the department of health has submitted/will submit all of the required NHM&E data (HIV Testing data, Partner Services data, Risk Reduction Activities (RRA) data, 2016 Funding Tables, as well as any other required aggregate data variables) to CDC via EvaluationWeb® and have committed/will commit them by the designated due date. And, that we have reviewed the EvaluationWeb® auto-populated PS12-1201 Data Tables.

2. Please include any additional comments and/or clarifications for your submitted NHM&E data and/or the PS12-1201 Data Tables. Please also include any justification(s) for partial/late data submission. Information provided will be used for consideration during the review process.

   ☐ No additional comments and/or clarifications needed.

   ☒ Additional comments and/or clarifications provided here:

Healthcare Settings in Category A

LAC primarily provides HIV testing in healthcare settings through Category B funding. However, there are some programs that provide targeted testing through Category A in both non-healthcare and healthcare settings. For this reason, 17,473 test events (including LB) are reported under Category A.

Note: *To better align the progress reporting and NHM&E data submission processes, as well as to reduce data burden, the quantitative NHM&E data entered into EvaluationWeb® will automatically populate the PS12-1201 Data Tables, with the exception of the tables included in this guidance. This report will draw directly from required NHM&E data that you have submitted to CDC via EvaluationWeb®. As a follow-up to your data submission, please review the PS12-1201 auto-populated quantitative data tables (for Category A and Category B) within EvaluationWeb®. These quantitative reports will be used by project officers in addition to the qualitative progress report for the review and feedback process.*

SECTION VII: ADDITIONAL INFORMATION

1. Additional Information

Please provide any other explanatory information or data you think would be important for CDC to receive (e.g., additional coordination and collaborations to support PS12-1201, local processes or procedures impacting program implementation).

None to report.

APPENDICES

Appendix A: Resource Allocation

Areas within the Jurisdiction with the Greatest Burden of HIV Disease

Identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For directly-funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease.

Reporting of MSAs/Cities/Areas with ≥ 30% of the HIV Epidemic within the Jurisdiction			
MSA/CITY/AREA	**Percentage of HIV Epidemic within the Jurisdiction**	**Percentage of PS12-1201 Funds Allocated**	**Components and Activities Funded**
Service Planning Area (SPA) 4	**39%**	**33%**	**HIV Testing Services, Risk Reduction Activities, and Social Marketing Activities (Erase Doubt and Condom Campaign)**
***In determining funds allocated by SPA, DHSP utilized the GEN (for SPA 4 is 26.5%). The GEN considered homelessness/poverty, HIV & STDs.**			

Appendix B: HIV Prevention and Care Planning Group (HPG)

HPG Membership and Stakeholder Profile
(January 1, 2016 – December 31, 2016)
This profile is to be completed annually by the HPG co-chairs (or appropriate designees).

Membership Profile	
Name of HPG/Jurisdiction:	Los Angeles County Commission on HIV
Type of HPG:	***Please select one:***
	☐ **Statewide** ☒ **Directly funded city/local jurisdiction**
Structure of HPG:	***Please select one:***
	☐ **Prevention Only**
	☒ **Integrated Prevention and Care** **Please provide the month/year the group integrated:** June 2013
	☐ **Other - Integrated with other planning bodies** **If your Planning Group is integrated with other planning bodies, please describe:**
Type of Plan:	***Please select one:***
	☐ **Integrated state/city prevention and care plan**
	☐ **Integrated state-only prevention and care plan**
	☐ **Integrated city-only prevention and care plan**
	☒ **Other:** Integrated County-only prevention and care plan
Types of Key Stakeholders represented as voting members (e.g., health department staff, PLWHA, CBOs, HOPWA, faith community):	Pursuant to County Ordinance Code 32.9, the following stakeholders represent our voting membership: (4) City/Health District members: represents health and social service institutions, who have epidemiology skills or experience and knowledge of Hepatitis B, C and STDs; (1) Director, Division of HIV and STD Programs (DHSP): represents RWP Part A grantee; (4) Ryan White Program Part B-F members: represents Ryan White grant recipients in the County

	(8) Provider members: represents organizations in the County selected to ensure geographic diversity and who reflect the epicenters of the epidemic, including: ▪ An HIV specialty physician from an HIV medical provider, ▪ A Community Health Center/Federally Qualified Health Center ("CHC"/ "FQHC") representative, ▪ A mental health provider, ▪ A substance abuse treatment provider, ▪ A housing provider, ▪ A provider of homeless services, ▪ A representative of an AIDS Services Organization ("ASO") offering federally funded HIV prevention services, and ▪ A representative of an ASO offering HIV care and treatment services; (17) Unaffiliated Consumer members: ▪ represents Service Planning Areas (SPA) 1-8 and who are recommended by consumers and/or organizations in the SPA, ▪ represents supervisorial district, who are recommended by consumers and/or organizations in the district, and ▪ consumers serving in an at-large capacity, who are recommended by consumers and/or organizations in the County (2) Board of Supervisors members: represents supervisorial offices (1) HOPWA member: (1) Local health/hospital planning agency member: represents a health plan in Covered California (1) Behavioral/Social Scientist member: represents the respective professional communities (6) HIV Stakeholder members: represents one or more of the following: ▪ Faith-based entities engaged in HIV prevention and care, ▪ Local education agencies at the elementary or secondary level, ▪ The business community, ▪ Union and/or labor, ▪ Youth or youth-serving agencies, ▪ Other federally funded HIV programs,

	▪ Organizations or individuals engaged in HIV-related research, ▪ Organizations providing harm reduction services, (3) Alternate member: represents a substitute for HIV-positive Commissioners when they cannot fulfill their respective Commission duties and responsibilities
Jurisdiction's website for HIV Planning, if available:	http://hiv.lacounty.gov
Web link for Integrated HIV Prevention and Care Plan, if available:	http://hiv/lacounty.gov

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
Solicitations Summary

Stage	Service Category	Actual/Est. Release Date	Est. Contract Start Date	Status/Notes
Contract Negotiations	Promoting Health Care Engagement	10/15/2015	7/1/2017	Conducting lengthy contract negotiations
	Temporary Medical Care Coordination (MCC) Services	9/19/2016	5/1/2017	Ongoing open solicitation for expanded MCC services; negotiating temporary agreements with 2 agencies to start May 2017; one contract is executed
Funding Recommendations	Mental Health Services	6/28/2016	8/1/2017	Health Deputy memo sent; following up on questions
	Mental Health Services in SPA 6	9/27/2016	8/1/2017	Health Deputy memo sent; following up on questions
	Prevention Services in Long Beach	8/17/2016	1/1/2018	Finalizing funding recommendations; sending health deputy memo beginning of May 2017
Released	Language Services	4/17/2017	3/1/2018	Proposals due May 22, 17; services to start by 3/1/18 or sooner
In Development	Legal Services	6/5/2017	3/1/2018	Final rough draft under review by DHSP; services to start 3/1/18 or sooner
	Medical Subspecialty Services	7/1/2017	3/1/2018	Final rough draft under review by DHSP
	Ambulatory Outpatient Medical (AOM)/MCC Services	8/1/2017	3/1/2018	AOM/MCC - C&G working on final rough draft; New MCC contracts will replace temporary agreements
	Oral Health Services (General/Specialty Dentistry)	9/6/2017	3/1/2018	DHSP developing FFS rates

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
Solicitations Summary

Stage	Service Category	Actual/Est. Release Date	Est. Contract Start Date	Status/Notes
Planning	Health Education/Risk Reduction Services	1/1/2018	1/1/2019	Planning underway; waiting for results of negotiations with Promoting Health and for new CDC FOA before developing RFP
	STD Screening Services	TBD	TBD	Planning meeting scheduled for May 1, 2017
	HIV Testing Services	1/1/2018	1/1/2019	
	Residential Care (RCFC & TRCF) Services	3/1/2018	3/1/2019	DHSP in discussions with DHS to use Master Agreement for Housing Health Program
	Substance Use Services	TBD	TBD	Working with SAPC to include a RWP client service category to the RFSQ they are developing for new substance use services
Completed	Biomedical Prevention Services WOS	3/7/2016	8/2/2016	Contracts in place; open continuous RFSQ
	Biomedical Prevention Services RFSQ	7/23/2015	N/A	Master Agreements completed
	STD Prevention Services in South LA	12/1/2014	3/10/2015	Contract in place
	Social Marketing/Media Services	10/24/2014	5/19/2015	Contract in place
Parking Lot	STD Social Marketing/Media Services	TBD	TBD	
	Nutrition Support Services	TBD	3/1/2019	
	Non-Medical Case Management	TBD	3/1/2019	Includes Benefits Specialty, TCM, and Jails
	Home-based Case Management	TBD	7/1/2019	